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TITLE 9. HEALTH SERVICES

CHAPTER 11. DEPARTMENT OF HEALTH SERVICES

HEALTH CARE INSTITUTIONS: RATES AND CHARGES INSTITUTION FACILITY DATA

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ARTICLE 1. GENERAL DEFINITIONS

R9-11-101. Definitions

- A.** ~~“Accrual” means recording revenues and expenses when incurred with specific periods of time, such as a month or year, without regard to the date of receipt or payment of cash.~~
- B.** ~~“Affiliated Organization” means the same as “related party.”~~
- C.** ~~“Annualized” means data for any period adjusted to represent a 12-month time period.~~
- D.** ~~“Charge Code” means a numeric or alpha-numeric identifier assigned by the health care institution to a unit of service such as a procedure, test, or commodity for which a separate charge is levied to a patient and used for identification on a patient’s itemized bill.~~
- E.** ~~“Charity Allowances” means reductions in charges for services made by the health care institution because of the indigence of the patient. This does not include Title XIX Arizona Health Care Cost Containment Service (AHCCCS) or any other third-party payor settlements.~~
- F.** ~~“Department” or “DHS” means the Department of Health Services.~~
- G.** ~~“Direct costs” means those costs which are incurred by and charged directly to the revenue-producing departments of the institution.~~
- H.** ~~“Director” means the Director of the Department.~~
- I.** ~~“Durable Medical Equipment” means reusable equipment a health care institution makes available for patient services. The equipment can be sold, rented or furnished at no cost to a patient.~~
- J.** ~~“Expendable” means those non-reusable commodities that may be sold to and are consumed by the patient.~~
- K.** ~~“Formula” means a defined mathematical progression applied to the cost of a product to calculate a patient charge.~~
- L.** ~~“Health care institution” or “institution” means every place, building or agency, whether organized for profit or not, which provides medical services, nursing services, or health-related services, except those institutions exempted by A.R.S. 36-402.~~
- M.** ~~“Indirect costs” means those costs which are incurred by and charged directly to the non-revenue-producing departments and then are proportionately allocated to the revenue-producing departments of the institution.~~
- N.** ~~“Inpatient hospice” means a hospice licensed by the Department pursuant to A.R.S. 36-405, 36-422 and A.A.C. Title 9, Chapter 10, Article 8 providing 24-hour inpatient care.~~
- O.** ~~“Level of Care” means categorizing patient services according to the type of care provided by the health care institution. Patient care factors, such as nursing hours, physical assistance or~~

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- ~~administration of medications, may be assigned numeric values generating accumulated or weighted points used to apply charges.~~
- P.** ~~“Managed Care” means services delivered to clients through a health maintenance organization, preferred provider organization, third party administrator or an independent physician association.~~
- Q.** ~~“Material” means a significant change in revenue or expense in relation to total revenue or significant changes that affect how a facility is managed or controlled.~~
- R.** ~~“Natural Classification” means the classification of expenses as reported on the income statement; i.e., the nature of the items as accrued, such as, salaries/wages, benefits, supplies, purchased services, insurance, and depreciation.~~
- S.** ~~“Nonexpendable” means those reusable items that may be rented or sold to the patient. This may include durable medical equipment.~~
- T.** ~~“Pass through” means any outside service or purchased commodity that is charged to a patient at the health care institution’s cost.~~
- U.** ~~“Private payor” means an individual or insurance company responsible for the payment of services. Third party government payor programs are not considered private payors.~~
- V.** ~~“Rate or Charge” means a separate dollar amount levied to a patient for use or consumption of a unit of service or commodity.~~
- W.** ~~“Related Party” means an investor (individual, partner or corporation) having more than 5% ownership of another entity.~~
- X.** ~~“Senior Plan” means contracted managed care services that are an alternate method of delivering services to Medicare eligible clients.~~
- Y.** ~~“Service” means a unit of care such as a procedure, test, or commodity for which a separate rate or charge is made to a patient.~~

In this Chapter, unless otherwise specified:

1. “Admission” or “admitted” means documented acceptance by a health care institution of an individual as an inpatient of a hospital, a resident of a nursing care institution, or a patient of a hospice.
2. “AHCCCS” means the Arizona Health Care Cost Containment System, established under A.R.S. § 36-2902.
3. “Allowance” means a charity care discount, self-pay discount, or contractual adjustment.
4. “Arizona facility ID” means a unique code assigned to a hospital by the Department to identify the source of inpatient discharge or emergency department discharge information.

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5. “Attending provider” means the medical practitioner who has primary responsibility for the services a patient receives during an episode of care.
6. “Available bed” means an inpatient bed or resident bed, as defined in A.R.S. § 36-401, for which a hospital, nursing care institution, or hospice has health professionals and commodities to provide services to a patient or resident.
7. “Bill” means a statement for money owed to a health care institution for the provision of the health care institution’s services.
8. “Business day” means any day of the week other than a Saturday, a Sunday, a legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.
9. “Calendar day” means any day of the week, including a Saturday or a Sunday.
10. “Cardiopulmonary resuscitation” means the same as in A.R.S. § 36-3251.
11. “Charge” means a specific dollar amount set by a health care institution for the use or consumption of a unit of service provided by the health care institution.
12. “Charge source” means the unit within a health care institution that provided services to an individual for which the individual’s payer source is billed.
13. “Charity care” means services provided without charge to an individual who meets certain financial criteria established by a health care institution.
14. “Chief administrative officer” means the same as in A.A.C. R9-10-101.
15. “Chief financial officer” means an individual who is responsible for the financial records of a health care institution.
16. “Classification” means a designation that indicates the types of services a hospital provides.
17. “Clinical evaluation” means an examination performed by a medical practitioner on the body of an individual for the presence of disease or injury to the body, and review of any laboratory test results for the individual.
18. “Commodity” means a non-reusable material, such as a syringe, bandage, or IV bag, utilized by a patient or resident.
19. “Contractual adjustment” means the difference between charges billed to a payer source and the amount that is paid to a health care institution based on an established agreement between the health care institution and the payer source.
20. “Control number” means a unique number assigned by a hospital for an individual’s specific episode of care.

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- 21. “Code” means a single number or letter, a set of numbers or letters, or a combination of numbers and letters that represents specific information.
- 22. “Department” means the Arizona Department of Health Services.
- 23. “Designee” means a person assigned by the governing authority of a health care institution or by an individual acting on behalf of the governing authority to gather information for or report information to the Department.
- 24. “Diagnosis” means the identification of a disease or injury, by an individual authorized by law to make the identification, that is a cause of an individual’s current medical condition.
- 25. “Discharge” means a health care institution’s termination of services to a patient or resident for a specific episode of care.
- 26. “Discharge status” means the disposition of a patient, including whether the patient was:
 - a. Discharged home,
 - b. Transferred to another health care institution, or
 - c. Died.
- 27. “DNR” means Do Not Resuscitate, a document prepared for a patient indicating that cardiopulmonary resuscitation is not to be used in the event that the patient’s heart stops beating.
- 28. “E-code” means an International Classification of Diseases code that is used:
 - a. In conjunction with other International Classification of Diseases codes that identify the principal and secondary diagnoses for an individual; and
 - b. To further designate the individual’s injury or illness as being caused by events such as:
 - i. An external cause of injury, such as a car accident;
 - ii. A poisoning; or
 - iii. An unexpected complication associated with treatment, such as an adverse reaction to a medication or a surgical error.
- 29. “Electronic” means the same as in A.R.S. § 36-301.
- 30. “Emergency” means the same as in A.A.C. R9-10-201.
- 31. “Emergency department” means the unit within a hospital that is designed for the provision of emergency services.
- 32. “Emergency services” means the same as in A.A.C. R9-10-201.
- 33. “Episode of care” means medical services, nursing services, or health-related services provided by a hospital to a patient for a specific period of time, ending with a discharge.

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- 34. "Fiscal year" means a consecutive 12-month period established by a health care institution for accounting, planning, or tax purposes.
- 35. "Governing authority" means the same as in A.R.S. § 36-401.
- 36. "Health care institution" means the same as in A.R.S. § 36-401.
- 37. "Health-related services" means the same as in A.R.S. § 36-401.
- 38. "Home health agency" means the same as in A.R.S. § 36-151.
- 39. "Home health services" means the same as in A.R.S. § 36-151.
- 40. "Home office" means the person that is the owner of and controls the functioning of a nursing care institution.
- 41. "Hospice" means the same as in A.R.S. § 36-401.
- 42. "Hospital" means the same as in A.A.C. R9-10-201.
- 43. "Hospital administrator" means the same as "administrator" in A.A.C. R9-10-201.
- 44. "Hospital services" means the same as in A.A.C. R9-10-201.
- 45. "International Classification of Diseases Code" means a code included in a set of codes such as the ICD-9-CM or ICD-10-CM codes, which is used by a hospital for billing purposes.
- 46. "Inpatient" means the same as in A.A.C. R9-10-201.
- 47. "Licensed capacity" means the same as in A.R.S. § 36-401.
- 48. "Management company" means an entity that:
 - a. Acts as an intermediary between the governing authority of a nursing care institution and the individuals who work in the nursing care institution.
 - b. Takes direction from the governing authority of the nursing care institution, and
 - c. Ensures that the directives of the governing authority of the nursing care institution are carried out.
- 49. "Medical practitioner" means an individual who is:
 - a. Licensed:
 - i. As a physician;
 - ii. As a dentist, under A.R.S. Title 32, Chapter 11, Article 2;
 - iii. As a podiatrist, under A.R.S. Title 32, Chapter 7;
 - iv. As a registered nurse practitioner, under A.R.S. Title 32, Chapter 15;
 - v. As a physician assistant, under A.R.S. Title 32, Chapter 25; or
 - vi. To use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state; or

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- b. Licensed in another state and authorized by law to use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state.
- 50. "Medical record number" means a unique number assigned by a hospital to an individual for identification purposes.
- 51. "Medical services" means the same as in A.R.S. § 36-401.
- 52. "Medicare" means a federal health insurance program established under Title XVIII of the Social Security Act.
- 53. "National provider identifier" means the unique number assigned by the Centers for Medicare and Medicaid Services to a health care institution, physician, registered nurse practitioner, or other medical practitioner to submit claims and transmit electronic health information to all payer sources.
- 54. "Newborn" means a human:
 - a. Whose birth took place in the reporting hospital, or
 - b. Who was:
 - i. Born outside a hospital,
 - ii. Admitted to the reporting hospital within 24 hours of birth, and
 - iii. Admitted to the reporting hospital before being admitted to any other hospital.
- 55. "Nursing care institution" means the same as in A.R.S. § 36-446.
- 56. "Nursing care institution administrator" means the same as in A.R.S. § 36-446.
- 57. "Nursing services" means the same as in A.R.S. § 36-401.
- 58. "Patient" means the same as in A.A.C. R9-10-101.
- 59. "Payer source" means an individual or an entity, such as a private insurance company, AHCCCS, or Medicare, to which a health care institution sends a bill for the services provided to an individual by the health care institution.
- 60. "Physician" means an individual licensed as a doctor of allopathic medicine under A.R.S. Title 32, Chapter 13, as a doctor of naturopathic medicine under A.R.S. Title 32, Chapter 14, or as a doctor of osteopathic medicine under A.R.S. Title 32, Chapter 17.
- 61. "Principal diagnosis" means the reason established after a clinical evaluation of a patient to be chiefly responsible for a specific episode of care.
- 62. "Principal procedure" means the procedure judged by an individual working on behalf of a hospital to be:
 - a. The most significant procedure performed during an episode of care, or

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- b. The procedure most closely associated with a patient's principal diagnosis.
- 63. "Priority of visit" means the urgency with which a patient required medical services during an episode of care.
- 64. "Procedure" means a set of activities performed on a patient that:
 - a. Is intended to diagnose or treat a disease, illness, or injury;
 - b. Requires the individual performing the set of activities be trained in the set of activities; and
 - c. May be invasive in nature or involve a risk to the patient from the activities themselves or from anesthesia.
- 65. "Prospective payment system" means a system of classifying episodes of care for billing and reimbursement purposes, based on factors such as diagnoses, age, and sex.
- 66. "Refer" means to direct an individual to a health care institution for services provided by the health care institution.
- 67. "Referral source" means a code designating the entity that referred or transferred a patient to a hospital.
- 68. "Registered nurse practitioner" means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.
- 69. "Reporting period" means the specific fiscal year, calendar year, or portion of the fiscal or calendar year for which a health care institution is reporting data to the Department.
- 70. "Residence" means the place where an individual lives, such as:
 - a. A private home,
 - b. A nursing care institution, or
 - c. An assisted living facility.
- 71. "Resident" means the same as in:
 - a. A.A.C. R9-10-701, or
 - b. A.A.C. R9-10-901.
- 72. "Revenue code" means a code for a unit of service that a hospital includes on a bill for hospital services.
- 73. "Secondary diagnosis" means any diagnosis for an individual other than the principal diagnosis.
- 74. "Self-pay discount" means a reduction in charges billed to an individual.

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75. “Service” means an activity performed as part of medical services, hospital services, nursing services, emergency services, health-related services, hospice services, home health services, or supportive services.
76. “Supportive services” means the same as in A.R.S. § 36-151.
77. “Transfer” means discharging an individual from a health care institution so the individual may be admitted to another health care institution.
78. “Trauma center” means the same as in:
- a. A.R.S. § 36-2201, or
 - b. A.R.S. § 36-2225.
79. “Treatment” means the same as in R9-10-101.
80. “Type of” means a specific subcategory of the following that is provided, enumerated, or utilized by a health care institution:
- a. An employee or contracted worker;
 - b. An accounting concept, such as asset, liability, or revenue;
 - c. A non-covered ancillary charge;
 - d. A payer source;
 - e. A charge source;
 - f. A medical condition; or
 - g. A service.
81. “Type of bed” means a category of available bed that specifies the services provided to an individual occupying the available bed.
82. “Unit” means an area within a health care institution that is designated by the health care institution to provide a specific type of service.
83. “Unit of service” means a procedure, service, commodity, or other item or group of items provided to a patient or resident for which a health care institution bills a payer source a specific amount.
84. “Written notice” means a document that is provided:
- a. In person,
 - b. By delivery service,
 - c. By facsimile transmission,
 - d. By electronic mail, or
 - e. By mail.

ARTICLE 3. RATES AND CHARGES SCHEDULES

R9-11-301. ~~Filing of Rates and Charges~~ Definitions

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- A.** ~~Each hospital, nursing care institution, supervisory care facility, and home health agency shall file with the Department all schedules of rates or charges, and other information specified in subsection (F) of this rule. This information shall be regarded as the existing schedule of rates or charges for such institutions.~~
- B.** ~~A new hospital, nursing care institution, supervisory care facility or home health agency shall not engage in business within this state until its schedule of rates or charges has been filed with the Department and reviewed as provided in A.R.S. § 36-436 et seq.~~
- C.** ~~No rate or charge for a new service or procedure shall be implemented by a hospital or nursing care institution until the requirements of A.R.S. § 36-421 and § 36-436 have been completed in accordance with the following:~~
 - ~~1. Rates or charges for a new service or procedure not requiring a permit pursuant to A.R.S. § 36-421 shall be filed with the Director and accompanied by a per-unit cost analysis using direct expense by natural classification, and number of units anticipated over a 12-month period. The Director may issue written findings. Upon submission of all required information, rates will be effective no later than 60 days subsequent to the filing. A schedule of rates and charges for a new service not requiring a permit shall be submitted no more than once quarterly.~~
 - ~~2. Rates or charges for a new service or procedure requiring a permit pursuant to A.R.S. § 36-421 shall be accompanied by an analysis consisting of two consecutive 12-month periods projecting each of the following elements:~~
 - ~~a. Volume in units,~~
 - ~~b. Gross Revenue,~~
 - ~~c. Deductions from Revenue,~~
 - ~~d. Direct expenses by natural classification, and~~
 - ~~e. Indirect expenses.~~
- D.** ~~No decrease or deletion shall be made by any hospital or nursing care institution in any rate or charge until the proposed decrease or deletion has been filed for informational purposes with the Director.~~
- E.** ~~Supervisory care and home health agencies shall submit to the Department increases in rates or charges 30 days prior to implementation.~~
- F.** ~~All schedules of rates or charges required to be filed shall include each service and item for which a separate charge is made. The schedule of rates or charges must contain the following information:~~
 - ~~1. Facility License Number;~~

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2. Facility Name;
 3. Table of contents or record layout that defines the order or sort of the information that would enable the Department to easily locate items by charge code within each department;
 4. Department Name and Number;
 5. Charge Code;
 6. Service description;
 7. Existing Charge;
 8. Proposed Charge;
 9. A copy of all rules, criteria and discounts, such as acuity methodology, pricing rationale, and formulae which may in any way change, affect or determine any part of the aggregate of the rates or charges therein or the value of the services or commodities covered by the schedule.
- G.** The schedule of rates or charges may be submitted in an electronic format if written approval has been granted by the Department prior to submission.
- H.** Charges for expendable items received from an outside supplier (excluding capital items for which the patient does not acquire ownership), which are generally numerous in quantity and subject to frequent cost changes, such as pharmacy or central supply items, may be listed on the schedule of rates and charges in the form of a formula, provided that the formula is adopted as a rule or regulation of the institution. The formula shall include, but is not limited to, the following elements:
1. The net purchase cost of the item, which shall reflect all invoiced discounts, allowances or rebates.
 2. The percent of cost or dollar markup.
- I.** If the formula method of listing rates and charges is used, the institution is not required to report or file those rate changes resulting exclusively from a change in the net purchase cost of the item to the institution. Any change in other elements of the formula shall constitute a change in the rate schedule and will require filing of the proposed new rate as provided in A.R.S. §§ 36-436.02 and 36-436.03.
- J.** If a charge is priced for outside services rendered by those individuals licensed pursuant to A.R.S. Title 32 or facilities licensed pursuant to A.R.S. Title 36, Article 4, the schedule of rates and charges shall include the pricing policy or formula.

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- K.** ~~The effective date of a proposed schedule of rates or charges of a new institution or of a change in the schedule of rates or charges of an existing institution shall be as determined by the institution but not earlier than:~~
- ~~1. The date of the findings of the Director, or~~
 - ~~2. Sixty days after the date of filing the proposed schedule together with all supporting data required by A.R.S. § 36-436 and subsections (F) through (J) of this Section, whichever occurs first.~~
- L.** ~~The filing date shall be determined by the Department as defined in R9-11-303 and R9-11-305.~~
- M.** ~~If increased rates or charges are not reflected on the patient bills along with discounts, if any, within 30 days after the review period has expired, the institution abandons its right to implement the increased schedule of rates or charges unless written consent is granted by the Director prior to the expiration of the 30-day period.~~

In this Article, unless otherwise specified:

1. “Adolescent” means an individual the hospital designates as an adolescent based on the hospital’s criteria.
2. “Adult” means the same as in A.A.C. R9-10-201.
3. “Behavioral health service” means the same as in A.A.C. R9-20-101.
4. “Blood bank cross match” means a laboratory analysis, performed by a facility that stores and preserves donated blood, to test the compatibility of a quantity of blood donated by one individual with another individual who is the intended recipient of the blood.
5. “Complete blood count with differential” means enumerating the number of red blood cells, platelets, and white blood cells in a sample of an individual’s blood, and including in the enumeration of white blood cells the number of each type of white blood cell.
6. “Contrast medium” means a substance opaque to x-rays, radio waves, or electromagnetic radiation that enhances an image of internal body structures.
7. “CT” means Computed Tomography, a diagnostic procedure in which x-ray measurements from many angles are used to provide images of internal body structures.
8. “Current rates and charges information” means the most recent rates and charges schedule for a health care institution on file with the Department, plus all documents changing the most recent rates and charges schedule.
9. “Drug” means the same as in A.R.S. § 32-1901.
10. “EEG” means electroencephalogram, a diagnostic procedure used to measure the electrical activity of the brain.

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11. “EKG” means electrocardiogram, a diagnostic procedure used to measure the electrical activity of the heart.
12. “Facility” means a building and associated personnel and equipment that perform a particular service or activity.
13. “Formulary” means a list of drugs that are available to a patient through a hospital.
14. “Home health agency” means the same as in A.R.S. § 36-151.
15. “Home health agency administrator” means the chief administrative officer for a home health agency.
16. “Hospital department” means a subdivision of a hospital providing administrative oversight for one or more charge sources.
17. “Implementation date” means the month, day, and year a health care institution intends to begin using specific rates and charges when billing a patient or resident.
18. “Intensive care bed” means an available bed used to provide intensive care services, as defined in A.A.C. R9-10-201, to a patient.
19. “IVP” means intravenous pyelography, a diagnostic procedure that uses an injection of a contrast medium into a vein and x-rays to provide images of the kidneys, ureters, bladder, and urethra.
20. “Labor and delivery” means services provided to a woman related to childbirth.
21. “Lithotripsy” means a procedure that uses sound waves to break up hardened deposits of mineral salts inside the human body.
22. “Mark-up” means the difference between the dollar amount a hospital pays for a drug, commodity, or service and the charge billed to a patient.
23. “MRI” means Magnetic Resonance Imaging, a diagnostic procedure that uses a magnetic field and radio waves to provide images of internal body structures.
24. “Neonate” means the same as in A.A.C. R9-10-201.
25. “Nursery bed” means an available bed used to provide hospital services to a neonate.
26. “Outpatient treatment center” means the same as in A.A.C. R9-10-101.
27. “Outpatient treatment center administrator” means the chief administrative officer for an outpatient treatment center.
28. “Overview form” means a document:
 - a. Submitted by a hospital to the Department as part of a rates and charges schedule or a change to the hospital’s current rates and charges information, and
 - b. That contains the information required in R9-11-302(B)(2) for the hospital.
29. “Pediatric” means the same as in A.A.C. R9-10-201.

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- 30. “Pediatric bed” means an available bed used to provide hospital services to a pediatric patient.
- 31. “Physical therapy” means the same as in A.R.S. § 32-2001.
- 32. “Post-hospital extended care services” means the services that are described in and meet the requirements of 42 CFR 409.31.
- 33. “Private room” means a room that contains one available bed.
- 34. “Rate” means a specific dollar amount per unit of service set by a health care institution.
- 35. “Rates and charges schedule” means a document that meets the requirements of A.R.S. Title 36, Chapter 4, Article 3 and contains the information required in R9-11-302(B) for hospitals, R9-11-303(A)(2) for nursing care institutions, R9-11-304(A)(2) for home health agencies, or R9-11-305(A)(2) for outpatient treatment centers.
- 36. “Review” means an analysis of a document to ensure that the document is in compliance with the requirements of this Article.
- 37. “Semi-private room” means a room that contains two available beds.
- 38. “Skilled nursing bed” means an available bed used for a patient requiring skilled nursing services.
- 39. “Skilled nursing services” means nursing services provided by an individual licensed under A.R.S. Title 32, Chapter 15.
- 40. “Small volume nebulizer” means a device that:
 - a. Holds liquid medicine that is turned into a mist by an air compressor, and
 - b. Is used for treatments lasting less than 20 minutes.
- 41. “Swing bed” means an available bed for which a hospital has been granted an approval from the Centers for Medicare and Medicaid Services to provide post-hospital extended care services and be reimbursed as a swing-bed hospital.
- 42. “Swing-bed hospital” means the same as in 42 CFR 413.114.
- 43. “Trauma team activation” means a notification by a health care institution:
 - a. That alerts individuals designated by the health care institution to respond to a particular type of emergency;
 - b. That is based on a patient’s triage information; and
 - c. For which the health care institution uses Revenue Category 068X of the National Uniform Billing Committee, UB-04 Data Specifications Manual to bill charges.
- 44. “Ultrasound” means a diagnostic procedure that uses high-frequency sound waves to provide images of internal body structures.

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R9-11-305. ~~Financial Report for Nursing Care Institution Rate Changes; Preparation and Filing Instructions~~ Outpatient Treatment Center Rates and Charges Schedule

- A.** ~~Form 302 shall be prepared and filed by all Nursing Care Institutions (NCI) proposing increases in rates and charges.~~
- B.** A hospital based NCI, licensed for 60 beds or less, may apply in writing to the Department for a waiver from completing Form 302. The waiver request shall be submitted prior to proposing an increase in rates and charges of the NCI. The hospital based NCI shall document in the application that the following apply:
 - 1. The NCI is separated from the hospital campus by no more than one common public or private thoroughfare;
 - 2. The hospital includes the NCI as a discrete operating department in the Financial Report for Review of Proposed Rate Increases — Hospitals, Form 301; and
 - 3. The NCI charges are included in the hospital's charge master.
- C.** ~~No proposed rate shall be charged to patients until the Director has issued findings on the proposed increase, or 60 days have elapsed from the date of a completed filing, as determined by the Department, whichever occurs first.~~
- D.** A complete rate package shall include:
 - 1. ~~A complete and accurate Form 302.~~
 - 2. Schedule of current and proposed rates and charges for all services rendered to patients according to the NCI's level of care definitions together with a copy of the rules and criteria as defined in R9-11-301.
 - 3. ~~Written justification for a rate increase and the planned date of implementation.~~
 - 4. A copy of the current management agreement and lease, if applicable.
 - a. ~~Detail of management fees and corporate cost allocations charged from a home office including the methodology used to determine the allocations and fees.~~
 - b. Details of lease expense paid to a related party for property, plant and equipment, submitted with Form 302 in a supplemental schedule which shall include cost, depreciation basis, debt amortization (interest expense and principle payments) for the applicable assets.
- E.** All required reports and documents pursuant to A.R.S. § 36-125.04 and A.A.C. R9-11-305(D) shall be complete and on file with the Department before a filing date is established. Incomplete reports shall not be accepted unless prior written approval to omit specified information has been

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~~obtained from the Department. Form 302 shall not be considered as filed, and the 60-day review period shall not commence, until receipt of all the required information.~~

- ~~1. Information may be requested by the Department after the initial review of the application in order to clarify any financial or statistical data contained in the rate package.~~
- ~~2. The 60-day review period shall begin from the most recent submission date if the information submitted by the institution at the Department's request or submitted due to revisions initiated by the institution, results in any of the following for the Base Year or Projected Year:~~
 - ~~a. A modification to the schedule of proposed rates and charges.~~
 - ~~b. A change in annual revenue that exceeds 0.5% of the original submittal.~~
 - ~~c. A change in annual operating expense that exceeds 0.5% of the original submittal.~~
 - ~~d. A modification of the Statement of Cash Flows.~~

F. ~~The following general instructions apply to the preparation of Form 302:~~

- ~~1. Each NCI shall submit a completed Form 302 to the Department in an electronic format supplied by the Department and a printout of the report. A manual Form 302 shall be accepted in lieu of an electronic format.~~
- ~~2. If schedules or sections are not applicable, those lines should be left blank. Any or all items left blank are subject to the approval of the Department.~~
- ~~3. No printed line item descriptions, titles, or column headings shall be altered or changed.~~
- ~~4. An institution may supplement Form 302 with additional information necessary to justify the proposed increase.~~
- ~~5. Financial amounts shall be rounded to the nearest dollar amount.~~
- ~~6. If the date of the filing is within the first six months of the institution's current fiscal year, the following reporting periods shall apply:~~
 - ~~a. "Base Year" means the fiscal year immediately preceding the filing date predicated on actual information, plus the estimated results for the balance of the year, if applicable.~~
 - ~~b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.~~
 - ~~c. "Projected Year" means the current fiscal year predicated on actual year-to-date information, plus the projected results for the balance of the year.~~

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7. ~~If the date of the filing is within the last six months of the institution's current fiscal year, the following reporting periods shall apply:~~
- a. ~~"Base Year" means the current fiscal year predicated on actual year-to-date information, plus the estimated results for the balance of the year.~~
 - b. ~~"Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.~~
 - c. ~~"Projected Year" means the fiscal year subsequent to the "Base Year" predicated entirely on projected results.~~

A. Before an outpatient treatment center provides services to patients, an outpatient treatment center administrator or designee shall submit to the Department a rates and charges package that contains:

1. A cover letter that includes:
- a. The name, physical address, mailing address, county, and telephone number of the outpatient treatment center;
 - b. The identification number assigned to the outpatient treatment center:
 - i. By the Department;
 - ii. By AHCCCS;
 - iii. By Medicare, if applicable; and
 - iv. As the outpatient treatment center's national provider identifier;
 - c. The name, telephone number, and e-mail address of:
 - i. The outpatient treatment center administrator,
 - ii. The outpatient treatment center chief financial officer, and
 - iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and
 - d. The planned implementation date for the rates and charges;
2. Either:
- a. A rates and charges schedule, in a format specified by the Department, containing:
 - i. A table of contents;
 - ii. For each unit of service offered for which a separate rate or charge is billed:
 - (1) The unit of service code,
 - (2) A description of the unit of service, and

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- (3) The rate or charge for the unit of service; and
 - iii. A copy of any outpatient treatment center rules or formulae which may affect the rate or charge for a unit of service; or
 - b. Current cost reports and financial information that the outpatient treatment center files for other government reporting purposes if the current cost reports and financial information submitted to the Department contain the information required in subsections (A)(2)(a)(ii) and (A)(2)(a)(iii); and
 3. A statement signed by the outpatient treatment center administrator or designee, on a form provided by the Department, attesting that, to the best of the knowledge and belief of the outpatient treatment center administrator or designee, the information submitted according to subsections (A)(1) and (2) is accurate and complete.
- B.** To change an outpatient treatment center's current rates and charges information, an outpatient treatment center administrator or designee shall submit to the Department:
1. A cover letter:
 - a. Containing the information specified in subsection (A)(1), and
 - b. Stating that the accompanying information is changing the outpatient treatment center's current rates and charges information;
 2. Either:
 - a. The rates and charges schedule specified in subsection (A)(2)(a) or the current cost reports and financial information specified in subsection (A)(2)(b); or
 - b. The following information:
 - i. A description of:
 - (1) The current and new rate or charge for each unit of service undergoing a change, and
 - (2) The current and new rules and formulae for each change to the outpatient treatment center rules or formulae which may affect the rate or charge for a unit of service;
 - ii. The line number or page number in the outpatient treatment center's current rates and charges information for each change listed in subsection (B)(2)(b)(i); and
 - iii. A list of each previous change:
 - (1) To a rate, charge, rule, or formula being changed;
 - (2) That was submitted since the last submission made according to subsection (A)(2) or (B)(2)(a); and

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(3) Including:

- (a) The date the rate, charge, rule, or formula was previously changed; and
- (b) A description of how the rate, charge, rule, or formula was previously changed; and

3. A statement signed by the outpatient treatment center administrator or designee, on a form provided by the Department, attesting that, to the best of the knowledge and belief of the outpatient treatment center administrator or designee, the information submitted according to subsections (B)(1) and (B)(2) is accurate and complete.

C. An outpatient treatment center administrator shall implement rates and charges for a rates and charges schedule submitted as specified in subsection (A) or for a change in the outpatient treatment center's current rates and charges information submitted as specified in subsection (B) on a date determined by the outpatient treatment center but not earlier than the date the Department notifies the outpatient treatment center that the Department received the rates and charges information.

D. When the Department receives from an outpatient treatment center a rates and charges schedule submitted as specified in subsection (A) or a change in the outpatient treatment center's rates and charges information submitted as specified in subsection (B), the Department shall provide written notice to the outpatient treatment center within five business days of receipt of the rates and charges information.

E. An outpatient treatment center administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the outpatient treatment center's current rates and charges information not prepared as specified in subsection (B), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:

- 1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
- 2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If an outpatient treatment center administrator or designee does not submit a rates and charges schedule or information about changes to the outpatient treatment center's rates and charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.